Healthcare: Japan’s case

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Outline

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5. Alternative Options and Scenarios
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1. Industry Profile

Small expenditure on health
- 8% of GDP (2008) ⇔ US (16%) and FRA (11%)
- 2,878 USD per capita ⇔ 3,101 USD (OECD avg.)

• But, labor market is growing
  - in the number of employed persons (Chart 1)
  - in the number of un-fulfillment of job offers (Chart 3)
  - in the number of practicing physicians/nurses (Chart 4 and 7)

• Geographically imbalanced distribution of workers
  - physicians and nurses (Fig. 1 and 4: below the OECD avg.)
2. Migrant Employment Patterns

Small number of immigrant workers
– less than 1% of total workers (e.g. physicians: Chart 4)
• Similarity in the role of local/migrant workers
  (e.g. physicians: Chart 11)
• Similarity in the distribution of local/migrant workers
  physicians: Figure 1)
• Local/migrant workers and the area of no-physicians
  physicians: Figure 5)

=> Immigrant workers cannot be alternative or solution for staff shortage, imbalanced distribution between urban/rural areas.

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3. The Effects of Migrants

Conclusions of the previous section imply that the small number of immigrant practitioners cannot have substantial impact on the recruitment, remuneration and retention of local/Japanese practitioner.

- No impact on recruitment:
  - The MHLW does not figure in foreign practitioners when it makes human-resource plan, although Japan is faced with staff shortage.

- No impact on remuneration/pay:
  - Remuneration in healthcare sector is lower than other sectors (Chart 16 and 17).
  - It correlates to the self-employed or not, and the size of hospital/clinic (Chart 18 and 21).

- No impact on retention (length of work):
  - Retention tends to be shorter than other sectors (Chart 22 and 23).
  - It correlates to the self-employed or not, and the size of hospital/clinic (Chart 24 and 27).

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4. Links between Migration, Labor and Other Policies – General Policy Framework –

The MHLW does not allow mutual recognition of qualifications/licenses
• The MHLW does not see healthcare as the sector of competitiveness
• It does not figure in immigrant worker

Therefore,
• Immigrants have to pass the national exams held in Japan, if they want to practice in Japan
• Also, fluency in Japanese is reviewed before taking exams (interview test)
• Furthermore certification of passing the Japanese-Language Proficiency Test is required (Grade N1) to take exams (*when immigrants do not graduate from Japanese junior- and senior-high schools)
4. Links between Migration, Labor and Other Policies – Bilateral Agreement under EPA-

Under the EPA, nurses and care workers from Indonesia and Philippines are allowed to work and practice in Japan *temporally* (not more than 3 years). They can stay and practice as they wish after passing the national exams in Japan, but *very few people can pass them* (Table 1 and 3).

- So far, the EPA does not function, due to conflicting political interests in a single policy framework:
  - promoting international cooperation (MOFA)
  - not a solution for the staff-shortage (MHLW)
  - protecting national labor market (equal pay) (JHA)
  - welcoming immigrant colleagues, even if educational and financial burden becomes heavier (host hospitals/clinics)

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5. Alternative Options and Scenarios

The MHLW makes it difficult for us to have an open and constructive discussion on immigrant workers

- the MHLW understands that the healthcare sector is not the sector of competitiveness, and
- it refuses to invite immigrant workers
- and emphasized to mobilize local workers, students, as well as early-retire worker
- reluctant to improve the EPA arrangement (⇔ MOFA and the cabinet)

• However, the MHLW’s approach is too cautious, because
  - requiring language proficiency easily constitutes a barrier for immigrant even in English-speaking countries (e.g. UK)
  - bilateral arrangement (such as the EPA) is a convenient tool for controlling immigrants (by introducing quota)

• A “Full-course” of regulation protects national labor market, as the MHLW believes in.
6. Concluding Remarks

- This case study is probably a special case, because ...  
  - the MHLW does not see healthcare as the sector of competitiveness  
  - the MHLW strongly regulates the inflow of immigrant workers, and attempts to mobilize only local workers, students and early-retirement workers to solve the staff-shortage  
  - even under the EPA, Japan cautiously uses two barriers: national exams and fluency of language

- However, Japan would have to discuss the recruitment of immigrant practitioners, in case of unprecedented aging population and severe staff shortage as well as imbalanced distribution between urban and rural areas

- To be prepared for such situation, further comparative studies between industries and countries are required to see the effect of regulations on immigrants, market and society

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Thank you very much for your attention!!
References

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Chart 1: Employed persons by industry

Source: Statistical Survey Department, Statistics Bureau, Ministry of Internal Affairs and Communications, Annual reports on the labour force survey.
Chart 3: The number of un-fulfillment of job offers in major industrial sectors (thousands)

Chart 4 (left): The number of registered physicians in Japan (Total and Foreign practitioners)

Chart 7 (right): The number of registered nurses in Japan
*no data of foreign practitioners*

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Chart 11: Components of registered physicians in 2010

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Chart 16 (left): Comparison of remuneration by industry, and the number of workforce (2002) *
* No specific data for information communication

Chart 17 (right): Comparison of remuneration by industry, and the number of workforce (2010)
Chart 18 (left): Trend in remuneration of physicians by the number of workforce

Chart 21 (right): Trend in remuneration of nurses by the number of workforce
**Chart 22 (left):** Comparison of retention by industry, and the number of workforce (2002) *

* No specific data for information communication


**Chart 23 (right):** Comparison of retention by industry, and the number of workforce (2010)

Chart 24 (left): Retention/Length of services by the number of workforce: Physicians  

Chart 27 (right): Retention/Length of services by the number of workforce: Nurses  
Figure 1: Physicians per 1,000 inhabitants and the number of foreign physicians


Physicians per 1,000 inhabitants (2010) and the number of foreign physicians (2010)
Figure 4: Nurses per 1,000 inhabitants (No data of the number of foreign nurses)
Figure 5: Areas with no physicians (2009) and the number of foreign physicians (2010)
Table 1 (left): Accepted Candidates for nurses and certified care workers by the EPA arrangement: Indonesian case

Table 3 (right): Results of the national nurse examination in 2011: Under the EPA arrangement (Indonesian candidates)

<table>
<thead>
<tr>
<th>Year</th>
<th>Candidate for Nurses</th>
<th>Candidate for Certified Care Workers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>104</td>
<td>104</td>
<td>208</td>
</tr>
<tr>
<td>2009</td>
<td>173</td>
<td>189</td>
<td>362</td>
</tr>
<tr>
<td>2010</td>
<td>39</td>
<td>77</td>
<td>116</td>
</tr>
<tr>
<td>2011</td>
<td>47</td>
<td>58</td>
<td>105</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Applicants</th>
<th>Successful candidate</th>
<th>Ratio of success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entrants in 2008</td>
<td>91</td>
<td>13</td>
<td>14.3%</td>
</tr>
<tr>
<td>Entrants in 2009</td>
<td>159</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Entrants in 2010</td>
<td>35</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
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